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# Labeling Theory and the Attitudes of Mental Patients: A Review

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*For years, critics and proponents of the labeling theory approach to mental illness have quarreled over society's reactions to the mentally ill. Heretofore, their debate has paid little attention to patients' reactions to labeling. This report reviews 35 studies dealing with (1) hospitalized patients' attitudes toward the label of mental illness and (2) ex-patients' attitudes toward the stigma or effects of hospitalization. Data are interpreted within the context of five propositions derived from labeling theory. None of the propositions met the criteria for acceptance. Labeling theory underestimated the degree to which patients and ex-patients think favorably about mental illness and posthospital experiences. Labeling theory also incorrectly predicted that patients' attitudes would become more unfavorable during hospitalization, as well as after discharge, and would be less favorable than nonpatients' attitudes. However, consistent with the theory, patients were strongly negative toward generalized labels of mental illness. The findings suggest that labeling theory in relation to mental illness needs to be reconsidered.*

The 1970's witnessed a formal, at times acrimonious, debate among sociologists concerning the merits and applicability of the societal reaction or labeling theory approach to mental illness. Proponents of the theory challenged the traditional psychiatric perspective and argued that the consequences of being labeled "mental patient" are malevolent, while critics contended that the patient role (hospitalization and treatment) is in the long run beneficial or benign. This debate was sparked by Gove's (1970) attack on Scheff's (1966) work; was fueled by a number of rebuttals and counter-rebuttals by Gove (1975a, 1975b, 1979) and Scheff (1974, 1975, 1979); and was widened by partisans on both sides (Chauncey, 1975; Rushing, 1971, 1978). The major points of contention between the critics (Gove, Chauncey) and proponents (Scheff, Rushing) were empirical findings from studies dealing with the outcomes of psychiatric examinations and court proceedings, patients' commitment status and social characteristics, relatives' definition of disturbed behavior and rejection of patients, public perceptions of mental illness, and the causes of rehospitalization. Particular findings were often utilized simultaneously to bolster and refute the importance of societal reactions in explaining psychiatric phenomena.[1]

Data on the attitudes of mental patients have heretofore *not* been one of the main points of contention in this ten-year wrangle. In his initial criticism of labeling theory, Gove (1970:881) cited only two patient attitude studies (Cumming and Cumming, 1965; Jones et al., 1963). He claimed that stigma, which results in feelings of rejection or expectations of discrimination, is not a serious problem for the mentally ill. Scheff (1974:449), in his first rebuttal to Gove, referred to two different patient attitude studies (Gove and Fain, 1973; Karmel, 1969) whose authors charge the findings do not support certain propositions derived from labeling theory. However, Scheff simply dismissed these studies as ambiguous, since there was no control group of similar persons who were not hospitalized. He failed to address the fact that most patients did not suffer a loss of self-esteem or identity in the hospital and did not feel their stay harmed them in any way. Later, in the continuing debate over societal reactions, Gove (1975b:59–64) and Chauncey (1975:249) cited these attitude studies again plus four more (Kotin and Schur, 1969; Linn, 1968; Mayer and

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Rosenblatt, 1974; Wood et al., 1960), and they reiterated earlier statements about the beneficial or benign effects of hospitalization. Counter-rebuttals by Scheff (1975, 1979) made no mention whatsoever of patients' attitudes.

Why is it that the attitudes of mental patients have not figured more prominently in the controversy over the merits of labeling theory? Several reasons come to mind. How patients view mental illness or hospital treatment was not a part of Scheff's (1966:40–93) original formulation of the societal reaction approach; his nine propositions dealt solely with the redefinition of psychiatric symptoms as residual deviance. Thus, there was no real foundation for later debate. Moreover, Scheff's failure to respond critically to the patient attitude data introduced by Gove and Chauncey at two different times (1970 and 1975) further diminished patients' reactions as a possible point of contention. There is much in labeling theory that is suggestive of how illness and hospitalization might be interpreted by the mental patient, but this line of reasoning was never explored by Scheff. In addition, perhaps patient attitude studies were not called upon more by sociologists because this literature, being chiefly psychological, was unfamiliar to them. (Dozens more than the eight studies cited by Gove, Scheff, and Chauncey exist.)

The lack of attention, especially by the proponents of labeling theory, to the attitudes of mental patients is indeed ironic. The societal reaction approach to deviance originated from the symbolic interactionist thought of George Herbert Mead. This approach places great emphasis on an individual's own definition of his/her deviance and the meanings attached to the label imposed by people or institutions (Cockerham, 1981:57–66). Yet, despite its interactionist parentage, labeling theory has focused almost exclusively on society's reactions to deviance and ignored the deviant's reaction to stigmatization. A number of sociologists, e.g., Akers (1968) and Schervish (1973), have been critical of labeling theory for just this incongruity. Even Lemert (1974:459), the first to identify the societal reaction approach, complained that labeling theory, as reformulated by others, has done a disservice to Mead because it unfortunately conveys an impression of the labeling process as unilateral, without a place for human choice or individuality.

Clearly, the attitudes of mental patients should be incorporated within, or at least taken into account by, labeling theory in its application to psychiatry. The present report adds to those of Gove (1975b:64) and Chauncey (1975:249) as a step in this direction. Here, 35 studies are reviewed in detail. The concern is with the literature that deals with (1) hospitalized patients' attitudes toward the label of mental illness and (2) ex-patients' attitudes toward the stigma or effects of hospitalization. These two types of studies appear to be germane to questions of societal reaction, and they have not been reviewed before.

The report has three major foci: First, five propositions about the patient's view of mental illness and posthospital experiences are derived from the works of labeling theorists. The general format for the derivation and presentation of these propositions is taken from Scheff (1966:40–93). As Greenley (1979:217–19) suggested, the propositions deal with selected aspects, rather than with the central tenets, of labeling theory. Second, empirical findings from the 35 patient attitude studies are reviewed in terms of the five propositions. Each proposition is evaluated by the number of studies whose results are supportive of or contrary to a societal reaction interpretation.[2] Third, labeling theory is then reconsidered in light of hospitalized patients' and ex-patients' reactions to labeling. Points of agreement and disagreement between the theory and reality of mental illness are discussed.

## LABELING THEORY PROPOSITIONS

Critics and proponents of labeling theory view mental illness and its treatment from different perspectives. The critics tend to adopt a psychiatric definition of illness, i.e., one which assumes the existence of psychopathology. The ill person is believed to have gross mental deterioration, disturbances in thought or mood, personality disintegration, anxiety reactions, or character defects, together with symptons such as hallucinations, delusions, depressive states, fears, inhibitions, uncontrollable urges, aggressivity, or antisocial behavior (American Psychiatric Association, 1980). Mental illness is seen as a "disorder"—an abnormal condition that has a

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definite etiology and is treatable in a medical mode. The mental hospital, as a site in which both to treat patients and shield them from the environment that is causing or contributing to their emotional problems, is cast in a positive light. The goal of treatment is to return the patient to the level of interpersonal functioning that existed prior to the onset of illness. After discharge, if there is a reappearance of psychiatric symptomatology, it is assumed to be related to the problems that precipitated the ex-patient's initial episode (Gove and Fain, 1973:494).

To proponents of labeling theory, on the other hand, mental illness is a label attached to those who engage in certain types of deviant activities. The symptoms and abnormal behavior characteristic of the mentally ill are seen as violations of social norms and as products of situations, rather than as the result of some personal predisposition or specific psychopathology (Scheff, 1966, 1974). Persons who are labeled mentally ill structure their deviance to conform to the behavioral expectations and cultural stereotypes of the mentally ill. Chronic mental illness is thus a social role, and the societal reaction is the most important determinant of entry into that role. Hospitalization is looked at in a negative context, because it tends to reinforce the very behavior it is supposed to correct. And once a person has been institutionalized for a mental disorder, he/she has been publicly labeled "crazy" and forced to become a member of a deviant social group. It is then difficult for the deviant to return to his/her former level of functioning as the status of "patient" causes unfavorable evaluations by self and others. When ex-patients are rehospitalized, it is generally believed to be due to the effects of social rejection and labeling, conditions having nothing to do with the person's alleged mental illness.

Proponents of labeling theory have created a conceptual framework for the interpretation of psychiatric phenomena. However, because they have said relatively little about the attitudes of mental patients, the derivation of specific propositions requires that bits and pieces of their writings on this topic be fused with general statements concerning societal reactions. Such propositions should deal with reactions to labeling, viz., the *favorableness* of patients' attitudes toward mental illness, hospitalization, and posthospital experiences. Two important issues, which were initially touched upon in the 1970's debate, are *how favorably* (a) patients and (b) ex-patients perceive psychiatric labels. Other issues worth investigating are *changes in the favorableness* of patients' attitudes (c) during hospitalization and (d) after discharge—and (e) the *relative favorableness* of patients' attitudes compared to those of nonpatients. The following labeling theory propositions cover these five issues.

*1. Hospitalized patients tend to espouse unfavorable attitudes toward mental illness.* Scheff (1966:64–86) maintains that everyone in society learns the stereotyped imagery of mental disorder through ordinary social interaction. From early childhood on, patients and nonpatients alike grasp the negative connotations of words such as "crazy," "nuts," and "looney" used to characterize disturbed persons. The mass media contributes to this bias against the mentally ill by continually connecting ex-patients with violent crimes and unpredictable acts. Unfavorable attitudes are evident in patients at the time of commitment, as they tend to claim they are not crazy and do not belong in the hospital. Scheff (1966:152) also believes that patients become extremely indignant and angry when they do not wish to be hospitalized but are forcibly treated. Another labeling theorist, Goffman (1961:142–52), contends that patients commonly sense that hospitalization is a massive unjust deprivation and that all patients feel some downgrading in the hospital. To retain their self-respect, patients mouth apologias or defensive lines against the negative fact of commitment.

*2. Patients' attitudes toward mental illness become more unfavorable during the course of hospitalization.* Labeling theorists argue that institutionalization, rather than curing patients of their psychopathology, only serves to exacerbate an ignominous self-image. Scheff's (1966:88–101) propositions about societal reaction stipulate that psychiatric treatment convinces patients they are "sick" and that there is considerable pressure on them in the hospital to accept the role of the mentally ill as part of their self-conception. The stigma attached to this role is so strong that patients' perceptions of themselves worsen and then, in a vicious circle, lead them to stabilize or amplify their deviant behavior. Goffman's

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(1961:14–43) notion of the "mortification of self" clearly intimates that patients' attitudes should become more unfavorable as time in the mental hospital increases. The process of institutionalization causes patients to be dispossessed from their normal social roles, experience feelings of humiliation, suffer loss of self-esteem, withstand verbal abuse from staff and other patients, and expose their private affairs.

*3. Patients are less favorable in attitude toward mental illness than nonpatients.* From a labeling point of view, it is presumed that those who have been institutionalized are less inclined than those who have not to think favorably about themselves, other patients, or their illness. The mental patient is a person who has been successfully labeled a deviant (Becker, 1973:9). The nonpatient, according to the theory, is someone who has not been "wronged" by society. Hence, the personal experience of deprivation and loss of freedom should cause patients to evaluate the social situation of the mentally ill more harshly than nonpatients.

*4. Ex-patients tend to express unfavorable attitudes toward the stigma of mental hospitalization.* Scheff (1966:87) claims the societal reaction process operates to systematically block labeled deviants' entry into non-deviant roles. Thus, former mental patients experience discrimination when they try to return to or find new occupational, marital, and social statuses. Phillips' (1963) experiment with public attitudes indicates that individuals who are described as seeking professional help for a psychiatric problem, especially in a mental hospital, are strongly rejected. Goffman (1961:355) notes that stigmatization is a basic factor in the life of the ex-patient, preventing an easy return to the social place he/she came from. Inasmuch as posthospital experiences are negative, the attitudes of ex-patients toward the effects of their hospitalization should be negative as well.

*5. Ex-patients' attitudes toward the stigma of mental hospitalization, compared to their pre-discharge attitudes, will be more unfavorable.* According to Scheff (1966:92–93), societal reaction is the single most important cause of a "career" of deviance. Ex-patients encounter greater amounts of rejection, embarrassment, and discrimination the longer they remain in the community, and they perforce revert to more deviant behavior. Attitudes towards the stigma attached to hospitalization should become more negative over time because the deviant role has become a greater part of the ex-patients' self-conception. After discharge, many patients fear rejection by others and feel uncertain about their ability to function in everyday roles (Clausen, 1981:293–94). The reappearance of psychiatric symptomatology or continued violation of social norms, a common problem for ex-patients, can likewise depress post-discharge attitudes.

## PATIENT ATTITUDE STUDIES

Survey of the literature revealed 35 patient attitude studies that could be utilized to examine these five propositions. Studies were selected on the basis of content and method. Requirements for inclusion were: The questions posed by researchers had to deal in some manner with attitudes toward the label of mental illness and the stigma or effects of hospitalization, and the findings had to be dichotomizeable as either "favorable" or "unfavorable." Only the studies in which attitudes were already classified by degree of favorableness or that we could interpret as such were reviewed. (Studies of how patients feel about hospital staff, ward atmosphere, treatment programs, aftercare services, rehospitalization, etc. were not included.) There were very few studies that had the content of concern to us but that were rejected because of the method.[3]

Outlined in Table 1 are 24 studies of patients' attitudes toward the label of mental illness. Patients primarily in state, veterans, and university hospitals were tested for their conceptions or evaluations of illness ideologies, of patient characteristics, of the patient role, and of social desirability of patients, as well as for their identification and acceptance of self as a patient. In Table 2, data from 12 studies of ex-patients' attitudes toward the stigma or effects of hospitalization are given. One study (Swanson and Spitzer, 1970) is represented in both Tables 1 and 2. Ex-patients, generally from three to 18 months after discharge, were questioned about their experiences of shame, rejection, and discrimination as a result of

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**TABLE 1. Studies of Hospitalized Patients' Attitudes Toward Label of Mental Illness**

| Study | Attitudes Measured | Techniques Used | Findings Reported |
|---|---|---|---|
| Backner and Kissinger (1963) | Evaluations of concept "mental patient" | Semantic differential — 7-point ratings on 19 adjective dimensions | Patients' ratings were low, in direction of unfavorable personal characteristics.[a] Ratings of general public were very similar. |
| Bentinck (1967) | Beliefs that mental patients in society should be dealt with in terms of: authoritarianism, benevolence, social restrictiveness | Three factor analytic scales from OMI Scale[b] | Patients were significantly less benevolent and less restrictive than their relatives. Both groups did not differ in authoritarianism. |
| Crumpton and Groot (1966) | Evaluations of concepts "mental patient," "nervous person," "schizophrenic," "crazy," "insane" | Semantic differential — 7-point ratings on 15 adjective dimensions | Patients' ratings on the 5 concepts were significantly higher than for control concept "person" on most dimensions, in direction of unfavorable personal characteristics.[a] |
| Crumpton et al. (1967) | Evaluation of concept "mental patient" | Semantic differential — 7-point ratings on 20 adjective dimensions | Patients' ratings on most dimensions compared to control concept "normal person" were significantly higher in direction of unfavorable personal characteristics.[a] Nonpatients' ratings were significantly less favorable than patients' on 10 dimensions. |
| Crumpton and Wine (1965) | Perceptions of "how a mental patient is" | Adjective checklist of 1607 words | Patients' words suggested more unfavorable personal characteristics[a] compared to their descriptions of a normal person. Nonpatients were more unfavorable than patients. |
| De Lange (1962) | Conceptions of mental patient role | Adjective checklist of 128 items | Patients and staff differed significantly. Patients tended to check traits and behaviors dealing with passivity and dependence, while staff emphasized assertiveness and independence. |
| Dinitz et al. (1959) | Conceptions of mental patient role | Adjective checklist of 128 items | Patients described themselves as modest, self-effacing, and dependent types, but saw their ideal self as domineering, forceful, self-confident, and responsible. Patients' descriptions did not differ from descriptions of them by relatives or staff. |
| Gallagher et al. (1957) | Views of mental illness and patients in custodial vs humanistic terms | CMI Scale[c] | Patients' mean score was slightly below midpoint of scale, indicating they were somewhat humanistic. Patients were significantly more custodially oriented than staff. |
| Giovannoni and Ullmann (1963) | Evaluations of concepts "neurotic man" and "insane man" | Semantic differential — 7-point ratings on 15 adjective dimensions | Patients described both concepts by reference to unfavorable personal characteristics.[a] Very few significant differences were found between patients' and nonpatients' evaluations. |
| Gynther and Brilliant (1964) | Views of mental illness and patients in custodial vs. humanistic terms | CMI Scale[c] | Patients' mean score was below midpoint, indicating a humanistic orientation. |
| Harrow et al. (1969) | Conceptions of social desirability of mental patients | 9-point agreement scale for 50 Q-sort items | Adult patients' ratings were significantly lower than ratings for "average person." Ratings by matched controls were significantly higher than those by patients. Patients' ratings were significantly higher at second testing, 2 months after admission. |

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**TABLE 1.** *(Continued)*

| Study | Attitudes Measured | Techniques Used | Findings Reported |
|---|---|---|---|
| Harrow et al. (1968) | Conceptions of social desirability of mental patients | 9-point agreement scale for 50 Q-sort items | Adolescent patients' ratings were significantly lower than ratings for "average person." Ratings by matched controls were significantly higher than those by patients. Patients' ratings were significantly higher at second testing, 2 months after admission. |
| Jones et al. (1963) | Expectations of maltreatment and social desirability as result of hospitalization | 4-point agreement scale for 4 statements | Patients disagreed that people who have been to mental hospitals are peculiar or treated differently, and strongly disagreed they are undersirable socially or not wanted by family or friends. |
| Karmel (1969) | Feelings of social desirability and identification of self as mental patient | 4-point agreement scale for 10 statements and Twenty Statements Test | At admission, 66% of patients had "high" social desirability and 68% had "high" social identity; one month later, 60% gained in social desirability and 78% had no change in social identity. |
| Kennard (1974) | Evaluations of concept "mentally ill person" | Semantic differential — 7-point ratings on 29 adjective dimensions | Patients' ratings were low, in direction of unfavorable personal characteristics.[a] Relatives' ratings were not significantly different. |
| Linn (1968) | Feelings of coerciveness, betrayal, loss, and undesirability as result of hospitalization | Open-ended questions | Most patients had favorable attitudes: 54% said they were not forced to come to hospital, 75% did not feel betrayed by relatives or friends, 58% did not expect any loss of individual rights, 53% did not expect a poorer reputation at home. |
| Manis et al. (1963) | Beliefs about hopelessness of mental illness and characteristics of mental patients | 4-point agreement scale for 18 statements | Patients did not believe mental disorder is incurable or that mentally ill are different in manner or appearance, have little will power, are not as good as other people. Patients were more favorable than staff and control group. One month later, patients' beliefs remained the same. |
| Mayo and Havelock (1970); Mayo et al. (1971) | Evaluations of concept "mental patient" | Semantic differential — 7-point ratings on 19 adjective dimensions | Patients' ratings were high, in direction of favorable personal characteristics.[d] Staff's ratings were significantly lower, in direction of unfavorable personal characteristics.[a] |
| | Views of mental illness in terms of custodialism | CMI Scale[e] | Patients were equally divided between custodialism and humanism. Wives and staff were significantly more humanistic. |
| | Authoritarian view of mental patients | 7-point agreement scale for 9 statements | Patients, wives, and staff tended to accept and not reject mental patients. |
| Quadagno and Antonio (1975) | Perceptions of label of mental illness | Open-ended questions | Most patients resisted label; they denied experiencing psychiatric symptoms, explained their condition as physical illness, claimed their problems are normal and shared by many people, insisted they have always been "in control" of themselves. |
| Swanson and Spitzer (1970) | Belief in necessity to avoid mental patients | 3-point agreement scale for 8 statements | At admission and some months later, patients tended to accept mental patients. Relatives were significantly more accepting than patients. |

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**TABLE 1.** *(Continued)*

| Study | Attitudes Measured | Techniques Used | Findings Reported |
|---|---|---|---|
| Teichman et al. (1974) | Acceptance of self as mental patient | Semi-projective test of 96 items | Before treatment, patients rejected themselves, socially and emotionally, significantly more often than they rejected their wives. After treatment, patients rejected themselves either less or just as often. |
| Townsend (1978) | Consideration of oneself as mentally ill | Open-ended questions | 25% of patients considered themselves mentally ill; 35% thought they belonged in hospital. |
| | Conceptions of curability of mental illness | Multiple-choice questions | Majority of patients believed all mental illnesses are curable and most patients are cured. |
| | Evaluations of concepts "mental patient" and "insane person" | Semantic differential — 7-point ratings on 30 adjective dimensions | Patients' ratings for both concepts on all dimensions were significantly higher, in direction of unfavorable personal characteristics,[a] than their ratings for control concept "average person." |
| Weinstein and Brill (1971) | Conceptions of mental illness etiology | Open-ended questions | Most patients believed mental illness is caused by interpersonal difficulties, and not heredity or organic problems. Nonpatients cited environmental and organic problems significantly more often. |
| Wood et al. (1960) | Expectations of mental patient status | Open-ended questions | 57% of patients said coming to the hospital was a good thing for their families; 4% thought hospitalization would adversely affect their job in any way. |

[a] Examples of unfavorable personal characteristics are: uncooperative, insincere, worthless, ineffective, undependable, unpredictable, twisted, ugly, dirty, sad, cruel, immoral, foolish, weak, passive, slow, dull, tense, unsuccessful, sick, dangerous, irresponsible, dependent.

[b] The Opinions About Mental Illness (OMI) Scale is a factor analytic scale comprised of 51 Likert-type items on five dimensions, three of which have relevance here. The factor of *authoritarianism* measures a view of the mentally ill as an inferior class requiring coercive handling, *benevolence* a paternalistic and humanistic view of patients, and *social restrictiveness* the belief that the mental patient is a threat to society, particularly the family, and must therefore be restricted in his/her functioning both during and after hospitalization.

[c] The Custodial Mental Illness Ideology (CMI) Scale contains 20 items in a 6-point agreement-disagreement format.

[d] The generally positive ratings centered around a view of the mental patient as clean, safe, warm, and good.

being in a mental hospital or about their perceptions of treatment effectiveness, symptom improvement, and community adjustment. Authors of studies in Tables 1 and 2 used a variety of methodological techniques to measure the different attitudes. Findings relating to the important issues of reactions to labeling (the favorableness of patients' attitudes, changes in the favorableness of patients' attitudes, and the relative favorableness of patients' attitudes compared to those of nonpatients) were chosen for presentation.

### *Measurement and Evaluation*

We encountered no difficulties, with either the Table 1 or Table 2 studies, in determining whether each finding relating to each measure of patients' attitudes was favorable or unfavorable.

In Table 1 studies using the semantic differential technique (Backner and Kissinger, 1963; Crumpton and Groot, 1966; Crumpton et al., 1967; Giovannoni and Ullmann, 1963; Kennard, 1974; Mayo et al., 1971; Townsend, 1978) or adjective checklists (Crumpton and Wine, 1965; De Lange, 1962; Dinitz et al., 1959), the adjectives rated suggested favorable or unfavorable characteristics of mental illness or patients. On the agreement-disagreement scales, each statement or item evaluated indicated a positive or negative description of illness or patients (Harrow et al., 1968, 1969; Jones et al., 1963; Karmel, 1969; Manis et al.,

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**TABLE 2. Studies of Ex-Patients' Attitudes Toward Stigma or Effects of Hospitalization**

| Study | Attitudes Measured | Techniques Used | Findings Reported |
|---|---|---|---|
| Allen and Barton (1976) | Feelings about care received in hospital | Open-ended questions | 19% of ex-patients gave favorable comments; 36% were neutral and 45% unfavorable. Attitudes were substantially less favorable than at predischarge period. |
| Chastko et al. (1971) | Helpfulness of nursing care received in hospital | 4-point rating scale for 1 statement, open-ended questions | 43% of ex-patients rated treatment very helpful; 40% said somewhat helpful and 17% claimed not helpful or made them worse. |
| Cumming and Cumming (1965) | Perceptions of shame or inferiority and expectations of discrimination as result of hospitalization | Unstructured interviews with indirect questions | 41% of ex-patients has specific feelings of embarrassment or a generalized anticipation of discrimination. |
| Gove and Fain (1973) | Belief that stay in hospital caused "harm in any way" and situation one year later is "any better or worse" | Multiple-choice questions | 14% of ex-patients claimed they were harmed by hospitalization; 59% said their situation back in the community improved and 37% felt situation did not change. |
| Kotin and Schur (1969) | Evaluation of hospital's helpfulness | 1 multiple-choice question | 53% of ex-patients felt hospital had been either very helpful or moderately helpful; 12% said slightly helpful and 17% believed not helpful or might have been harmful. |
| Miller and Dawson (1965) | Opinions about ability to work, discrimination, interpersonal relations | Open-ended questions | Half of sample indicated their status as former mental patient had created hardship for them in community; they experienced threats by relatives, distorted communication with others, loss of self-confidence, employment problems. |
| Nuehring (1979) | Perceptions of being shunned and rejected because of mental illness | 4-point agreement scale for 3 items | Ex-patients' score on stigma index was 6.2 of a possible 12 and clustered closely around mean. |
| Rosenblatt and Mayer (1974) | Perceptions of shame upon returning to hospital | Open-ended questions | Majority of ex-patients did not express feeling of shame or embarrassment at time of rehospitalization. |
| Small et al. (1965) | Recognition of illness and need for treatment, evaluation of effectiveness of hospitalization | Open-ended questions | Somewhat fewer than half of ex-patients accepted their psychiatric condition, felt coming to hospital was wise decision, and said treatment had been helpful. Attitudes were substantially more favorable than just prior to discharge. |
| Spiegel and Younger (1972) | Perceptions of adjustment to life outside hospital | Multiple-choice and open-ended questions | Most ex-patients thought they were not getting along well in community — were isolated socially, had no one to turn to for help, had been turned down for jobs because of psychiatric status, received little vocational assistance from hospital. |
| Swanson and Spitzer (1970) | Belief in necessity to avoid mental patients | 3-point agreement scale for 8 statements | Ex-patients tended to accept mental patients, and had scores similar to those of their relatives. Ex-patients' scores were significantly lower (signifying greater acceptance) than those taken during hospitalization. |
| Wood et al. (1962) | Perceptions of symptom improvement and occupational adjustment after discharge | Open- and closed-ended questions | 44% of ex-patients felt symptomatically improved since discharge; 61% reported increased satisfaction with work. |

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1963; Mayo et al., 1971; Swanson and Spitzer, 1970). Some of these studies corroborated the degree of positiveness toward psychiatric concepts via a simultaneous comparison of patients' attitudes toward various concepts of normal persons (Crumpton and Groot, 1966; Crumpton et al., 1967; Crumpton and Wine, 1965; Dinitz et al., 1959; Harrow et al., 1968, 1969; Townsend, 1978). In the factor analytic studies, favorableness was determined by the difference between the midpoint of the scale (Gallagher et al., 1957; Gynther and Brilliant, 1964; Mayo and Havelock, 1970) or subscales (Bentinck, 1967) and patients' mean scores. Scale or subscale scores reflected the degree of endorsement of particular attitudes, the content of which denotes a favorable or unfavorable view. With multiple-choice and unstructured tests, attitudinal favorableness was evident from the content of researchers' questions (Linn, 1968; Townsend, 1978), the content of patients' answers (Quadagno and Antonio, 1975; Townsend, 1978; Weinstein and Brill, 1971; Wood et al., 1960), or the way the data were interpreted (Karmel, 1969; Teichman et al., 1974).

In certain Table 2 studies (Allen and Barton, 1976; Swanson and Spitzer, 1970), researchers purposefully categorized ex-patients' replies by degree of favorableness. In other studies (Chastko et al., 1971; Gove and Fain, 1973; Kotin and Schur, 1969; Neuhring, 1979), the quality of positiveness was built into the different points of the scales used or the multiple-choices for the questions posed. With half of the Table 2 studies (Cumming and Cumming, 1965; Miller and Dawson, 1965; Rosenblatt and Mayer, 1974; Small et al., 1965; Spiegel and Younger, 1972; Wood et al., 1962), ex-patients' answers containing references to "embarrassment," "hardship," "improvement," or "help" ostensibly signified a favorable or unfavorable reply.

In the evaluation of the five propositions, the studies whose results were supportive of or contrary to labeling theory were counted in accord with the following criteria. To ascertain the overall favorableness of patients' attitudes (Propositions 1 and 4), the number of studies that had findings in a favorable direction was identified. "Favorable direction" meant either (a) if more than one question, test, or scale was used, more than half of the study's patients viewed some aspect of the label of mental illness or stigma of hospitalization positively or the total sample received a mean score on the positive side of the scale, or (b) if multiple measures were used, there was a majority of positive responses or of mean scores on a scale's positive side. In many cases, patients' favorableness on a particular measure or measures was apparent from researcher's tests of significance. For each study, findings in a favorable direction implied that patients exhibited a *tendency* — not a unanimity — to view mental illness or posthospital experiences positively. To determine changes in the favorableness of patients' attitudes (Propositions 2 and 5) and relative favorableness compared to nonpatient controls (Proposition 3), studies were counted on the basis of researcher's reporting of statistically significant differences or of substantial percentage differences.[4]

### *Tests of Propositions*

To test Proposition 1, the number of Table 1 studies that could be counted was 23. One study (Bentinck, 1967) was not included in this test because its subscale midpoints were not known. According to our criteria, patients tended to espouse favorable attitudes in 12 studies (Gallagher et al., 1957; Gynther and Brilliant, 1964; Jones et al., 1963; Karmel, 1969; Linn, 1968; Manis et al., 1963; Mayo and Havelock, 1970; Quadagno and Antonio, 1975; Swanson and Spitzer, 1970; Townsend, 1978; Weinstein and Brill, 1971; Wood et al., 1960) and unfavorable attitudes in 11 (Backner and Kissinger, 1963; Crumpton and Groot, 1966; Crumpton et al., 1967; Crumpton and Wine, 1965; De Lange, 1962; Dinitz et al., 1959; Giovannoni and Ullman, 1963; Harrow et al., 1968, 1969; Kennard, 1974; Teichman et al., 1974). Proposition 1 was not supported by the data, as patients summoned favorable images of mental illness labels slightly more often than unfavorable. Labeling theory appears to underestimate the positiveness of patients in different hospital samples.

These 23 studies in Table 1 contained 49 measures (questions, tests, scales) of hospitalized patients' attitudes. The data indicated that the frequency of favorable results varied considerably according to the type of attitude

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measured. We discovered that 16 of the 19 measures in the unfavorable column deal with *general* attitudes toward patient characteristics or behaviors, while 17 of the 30 measures in the favorable column concerned *self* perceptions or experiences. When talking about mental patients in the abstract, rather than about their own illness or hospitalization, patients were far less positive in their assessments of labeling. Thus, Proposition 1 *was* supported by the data, if individual measures, rather than study samples,[5] were the units of analysis and if attitudes toward mental illness labels were generalized rather than personalized.

The attitudes of hospitalized patients in five Table 1 studies were elicited at more than one time period, and these could be used to examine Proposition 2. The data showed that in all five studies (Harrow et al., 1968, 1969; Karmel, 1969; Manis et al., 1963; Teichman et al., 1974), patients' views either remained the same or changed for the better. Hospitalization did not cause patients to lower their opinions of themselves, other patients, or mental illness labels. Thus, Proposition 2 received no empirical support whatsoever. Labeling theory may have completely misjudged the direction that changes in patients' attitudes take.

Proposition 3 could be tested via 15 studies in Table 1. In four of these, patients' views proved to be more favorable than those of nonpatients (Crumpton et al., 1967; Crumpton and Wine, 1965; Manis et al., 1963; Weinstein and Brill, 1971); in five, just as favorable (Backner and Kissinger, 1963; Bentinck, 1967; Dinitz et al., 1959; Giovannoni and Ullman, 1963; Kennard, 1974); and in five, less favorable (De Lange, 1962; Gallagher et al., 1957; Harrow et al., 1968, 1969; Swanson and Spitzer, 1970). With the three different attitude measures of one study (Mayo and Havelock, 1970; Mayo et al., 1971), patients' attitudes were, respectively, more, less, and just as favorable as those of nonpatients. According to our criteria, therefore, Proposition 3 must be rejected. In its interpretation of the difference between patients' and nonpatients' attitudes toward the label of mental illness, labeling theory was correct in only about one-third of the cases.

The data in Table 2 concerning Proposition 4 revealed that the societal reaction framework correctly predicted how ex-patients felt about the stigma or effects of mental hospitalization approximately half of the time. Attitudes tended to be unfavorable in five studies (Allen and Barton, 1976; Miller and Dawson, 1965; Neuhring, 1979; Small et al., 1965; Spiegel and Younger, 1972); ambivalent in one (Wood et al., 1962); and favorable in six (Chastko et al., 1971; Cumming and Cumming, 1965; Gove and Fain, 1973; Kotin and Schur, 1969; Rosenblatt and Mayer, 1974; Swanson and Spitzer, 1970). Proposition 4 was not supported by the data in these 12 studies. Labeling theory appears to underestimate the positiveness of former patients in the community. Only one of the Table 2 studies (Swanson and Spitzer, 1970) dealt with ex-patients' attitudes in general, so comparisons with self-conceptions could not be made.

Findings from the three Table 2 studies that measured changes in ex-patients' attitudes indicated rather weak support for Proposition 5. In two studies (Small et al., 1965; Swanson and Spitzer, 1970), post-discharge views of stigmatization or treatment effectiveness, compared to pre-discharge, changed for the better, and in one (Allen and Barton, 1976), they changed for the worse. Labeling theory is thus off-target in two of the three cases. Proposition 5 was contradicted by these limited data. No conclusions could be drawn about ex-patients' attitudes relative to those of nonpatients, since only one study (Swanson and Spitzer, 1970) looked at this issue.

## LABELING THEORY RECONSIDERED

This review of 35 patient attitude studies yielded results that, according to our criteria for evaluation, did not support the labeling theory of mental illness for any of the five propositions considered. Slightly fewer than half of the studies used to test Propositions 1 and 4 reported findings that supported a societal reaction interpretation. In both cases, this was less than the clear majority needed for an acceptance of a proposition's claims. None of the studies used for testing Proposition 2 and only about one-third of those used for Propositions 3 and 5 contained data on patients' attitudes that upheld the labeling perspective. For these three propositions, the contradictory evidence was far greater.

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Pieces of data presented here suggest that particular aspects of labeling theory are correct, despite the fact that none of the five propositions were supported, according to our criteria. The test of Proposition 1 indicated that hospitalized patients have indeed learned the stereotyped imagery and negative connotations of mental disorder. A sizable majority (84%) of patients' responses to the Table 1 study measures dealing with general attitudes showed that mental patients were perceived in terms of unfavorable characteristics, e.g., as worthless, unpredictable, immoral, foolish, weak, sick, dangerous, irresponsible. Patients' negativeness was demarcated most clearly in all of the studies that compared attitudes toward both psychiatric and normal concepts. The test of Proposition 4 revealed that many ex-patients felt stigmatized as a consequence of hospitalization and found re-entry into social roles problematical. In about half of the Table 2 studies, a majority of ex-patients expressed negative attitudes because of lack of improvement, interpersonal difficulties, social rejection, and job discrimination.

In a number of ways, however, labeling theory has apparently misjudged patients' and ex-patients' reactions to labeling. First, hospitalized patients' beliefs in stereotypes and their negativeness toward other patients were ameliorated rather than exacerbated, when the mental illness labels were personalized. In the majority (57%) of Table 1 study measures of self-perceptions, patients responded favorably, i.e., they claimed they are in control of themselves, do not have a hereditary disease, have normal problems, were not forced to come to the hospital, and are desirable socially. Second, institutionalization caused most patients to accept, rather than reject, the mental patient role. None of the Table 1 studies indicated that patients' attitudes toward the label of mental illness changed for the worse between admission and discharge, and patients' attitudes tended to be more favorable than those of nonpatients. Third, ex-patients' evaluations of hospital and posthospital experiences suggested that they generally move away from, instead of toward, a career of social deviance. A majority of ex-patients in over half of the Table 2 studies said months after discharge that treatment was helpful, shame or embarrassment was not a problem, or their situation back in the community improved; moreover, these feelings were more favorable than those expressed prior to discharge.

Why does labeling theory presume patients and ex-patients to be more negative in orientation than they actually are? Theoretical and methodological biases associated with this perspective probably account for this. Killian (1981:236) claimed that sociologists, based on an anti-establishment and pro-underdog sentiment, generally think of the mentally ill as "victims" of society. Patients are believed to be "warehoused" in oppressive total institutions, where they are managed and punished by the authorities because of their troublesome behavior, and ex-patients are seen as objects of scorn who are at the mercy of a stigmatizing public. According to Killian, labeling theorists have imposed preconceived schemes on a reality which they themselves have not experienced. The research practices of sociologists also help to explain their misconceptions of patient life. Labeling theorists have studied the labeling process via masquerades as patients or participant observations of hospital wards, and these methodological techniques are not without bias (Weinstein, 1981:311). As they are not mentally ill, there is a tendency for pseudopatients to experience the discomfort of psychiatric treatment more keenly—and for observers to fail to take into account that hospitalization may alleviate psychic pain.

The lack of empirical support uncovered for labeling theory in this review is consistent with the findings of other researchers who have not been identified as either a critic or proponent of the perspective. Greenley (1979), for example, found no evidence that careers of psychiatric deviance are stabilized by societal reactions; ex-patients' level of symptomatology was not influenced by the symptom-relevant expectations of their family members and psychiatrists. And, more to the point of this report, Whitt et al. (1979) observed that labeling theory does not adequately explain the ways in which persons interpret their problematic feelings and behaviors. Patients significantly more often than nonpatients judged their problems as wrong and serious—but not as incurable or pathological.

Several critics of labeling theory have attempted to account for its poor test results. Killian (1981:231) argued that Scheff's analytic

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model is an "ideal type" that quickly came to be treated as an empirical type. This "vulgar" version of societal reaction seldom produces findings consistent with its theoretical underpinnings or the intentions of the original theorists. Gove (1979:301) maintained that labeling theory's empirical base is questionable, since sociologists have virtually ignored the research evidence of psychiatrists—those primarily responsible for the treatment of the mentally ill. Data generated from the labeling perspective, in Schervish's (1973:48) opinion, apply disproportionately to deviants in passive roles. Theorists have tended to study the most obvious and clearcut examples of labeling, in formal and structured institutional settings, which impose the fewest methodological problems. Quadagno and Antonio (1975:33) believed this emphasis on instances of successful labeling has caused theorists to disregard the victim's ability to reject deviant labels.

Data given here and in other studies suggest that the labeling theory of mental illness should be reconsidered in relation to a rather strong pattern of denial among patients. We noted that hospitalized patients invariably recognized the negativeness of mental illness labels in general, for other people, but they emitted a clearly positive tone when talking about their own experiences. Meile and Whitt (1981:238–41) learned that hospitalized and ambulatory patients rated behavioral and emotional traits associated with mental illness that they possessed more favorably than traits others possessed. There is nothing in labeling theory that considers the possibility that labeled deviants may deny the wrongfulness of their social and personal situation or the appropriateness of community evaluations of them. Yet the empirical evidence points indisputably to the fact that, in accord with the view of psychiatry, labeled deviants do try to legitimize their status. Mental patients are not affected by the labeling process as much as the theory presupposes. Societal reactions to disturbed behavior and mental hospitalization are acutely understood, but not internalized, by patients.

The critics (Gove and Howell, 1974:87) and proponents (Rushing, 1971:511) of labeling theory agree that both psychiatric phenomena and societal reactions are involved to some degree in most cases of mental hospitalization. The important question for research on any single topic in psychiatry, then, is the relative strength of each in explaining what typically occurs. The evidence in this review indicates that a traditional psychiatric perspective explains the attitudes of mental patients better than labeling theory. In 35 studies, attitudes toward the label of mental illness and stigma of hospitalization were favorable a little more often than unfavorable, and they became more favorable in the hospital and after discharge. Thus, patients seem to agree with psychiatry's view that the benefits of the patient role outweigh its losses. This fact is nicely illustrated in an autobiographical account of a patient who, ironically, was a sociologist initially fearful of labeling and its consequences (Killian and Bloomberg, 1975); hospitalization and treatment soon changed his attitude in a positive direction and he sensed no stigma after discharge.

This report represents a foundation from which the labeling theory of mental illness can be modified in future research with respect to the attitudes of patients. Our review of 35 patient attitude studies against the backdrop of general propositions yielded data that are highly suggestive of specific hypotheses concerning societal reactions. Such hypotheses — about patients' beliefs in mental illness stereotypes, acceptance of the patient role, denial of deviancy, perceptions of the helpfulness of hospitalization, feelings of stigma — should be tested with empirical data collected for this purpose.

In this review, we could only evaluate labeling theory propositions indirectly since the vast majority of studies considered here neither collected nor interpreted the data with this sociological perspective in mind. Four of the five studies from Tables 1 and 2 that framed patients' attitudes in terms of Scheff's or Goffman's theories contended that societal reaction formulations are either wrong or should be modified significantly (Gove and Fain, 1973; Karmel, 1969; Linn, 1968; Quadagno and Antonio, 1975). In one study (Swanson and Spitzer, 1970), it was claimed that Goffman's notion of stigma was substantiated, but according to our criteria, the patients tended to accept rather than reject other patients. Thus, further research is necessary to pinpoint the strengths and weaknesses of psy-

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chiatric labeling from the patient's point of view.

It is doubtful that anything in this report will abruptly end the debate between the critics and proponents of labeling theory. Over the years, casual statements turned into ideological positions; academic discussion gave way to polemical attacks; and undefined interests became vested properties. It is hoped, however, that our injection of mental patients' attitudes into the controversy over the merits of labeling theory will both alert social scientists to the importance of considering the reactions of labelees and provide future researchers with some useful tools to explore this heretofore neglected subject. One day, perhaps more extensive attitudinal data will help to make the societal reaction approach to mental illness more congruent with patients' reality.

## NOTES

1. It is interesting that less than a year before the formal debate began between the critics and proponents of labeling theory, Petroni and Griffin (1969) anticipated the potential conflict between the sociological and psychiatric approaches to mental illness. The trend toward collision was probably set in motion by the growth of community psychiatry in the 1960's and the increased involvement of sociologists in this field. Petroni and Griffin claimed that there was a dearth of empirical evidence to support the theoretical positions and assumptions of either approach on the consequences of the "mental patient" label. On the very eve of the controversy, they were prescient enough to remark that questions concerning the benefits or losses of the patient role should not and cannot be answered by polemics alone. These questions, it was exhorted, challenge the researcher and beg to be answered. The unremitting debate over labeling theory in the 1970's, especially the exchanges between Gove and Scheff, turned out to be largely polemical (Cockerham, 1981:68–72).
2. This method of evaluating a particular issue or position by counting the number of studies that support or contradict it has been used by sociologists (Brockman et al., 1979; Weinstein, 1979) and psychologists (Baekeland and Lundwall, 1975; Rabkin, 1974) in their reviews of the literature.
3. For example, Gruba and Johnson (1974) and Ishiyama (1964) studied attitudes pertinent to this report, mental patients' self-concepts and role image, but they tabulated their data in a manner that precluded determination of the degree of favorableness of these attitudes. In the former case, the number of pairs of contradictory personal adjectives endorsed by patients was measured, rather than their ratings of social desirability; in the latter the content of the role was looked at and not patients' approval or disapproval of it.
4. These criteria appeared to be the best way to assess the issues relating to attitudinal favorableness across the 35 Table 1 and Table 2 studies. In a review study such as this, it is often necessary to construct particular variables or devise methods of analysis in order to compare similar data that were measured differently. Like Brockman et al. (1979:677), we treated each item (measure) in each study independently and recorded the positive responses to that item. Like Baekeland and Lundwall (1975:762–69), we noted the frequency of group differences or changes among those studies considering a particular psychiatric or social variable.
5. Since several Table 1 studies with multiple measures elicited both general attitudes and self-perceptions, type of attitude could only be analyzed in terms of individual measures and not study samples. This method of using a test measure as well as a hospital sample as the unit of analysis in reviewing different studies was adopted from Weinstein (1979:249).

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